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BACKGROUND INFORMATION

Date: _____
Referred by: _____

PERSONAL/FAMILY DATA

Child's name: _____
Date of birth: _____
Age: _____
Parent's names: _____
Address: _____
_____
Phone: _____
_____
Email: _____
Best way to contact: _____
Siblings-names/ages: _____
_____
Parent occupations: _____
_____

CHIEF CONCERN

_____
_____
_____
_____

BIRTH HISTORY

Length of gestation period: _____
Type of delivery: _____
Any difficulties before, during, and/or after birth?

_____
_____

DEVELOPMENTAL MILESTONES

Speech milestones such as first word and first sentence were:
Delayed _____
Not delayed _____

Motor milestones such as sitting, crawling, walking were:
Delayed _____
Not delayed _____

Toilet training:
Delayed _____
Not delayed _____

MEDICAL HISTORY

Who is your child's pediatrician? _____

Please list any significant illnesses/hospitalizations, and/or surgeries, and the dates of occurrence:

_____
_____
_____
_____
_____
_____
_____

Does your child take any medications?

_____
_____

Does your child have:
Allergies? _____
Asthma? _____
Frequent colds? _____
Frequent congestion:? _____

Does your child snore?_____

Has hearing been checked? _____
Dates/results: _____
Ear infections? _____Approx. how many? _____
When was the last one? _____
Vision checked/results?_____

DENTAL/ORTHODONTIC HISTORY

Who is your child's dentist? _____
Any dental hygiene concerns? _____
_____
Any significant dental treatment?
_____
_____
_____
_____
_____

Who is your child's orthodontist?_____
Please list any orthodontic treatment (past, ongoing, planned)

_____
_____
_____
_____
_____
_____

EDUCATION

School: _____
Grade: _____
Strengths and weaknesses: _____
_____
_____
_____
_____

SOCIAL

How are your child's peer and family relations?

What does your child enjoy?

PREVIOUS/OTHER THERAPY/TREATMENT

Is your child currently, or has your child been enrolled before in any therapy or treatment (e.g. speech, psychological, occupational, physical, etc…)?

If so, please list dates and general treatment goals

CHILD ATTITUDE/VIEWPOINT

Has your child ever commented on his speech/oral-motor/swallowing difficulties?

How does your child feel about today's visit?

FAMILY/LANGUAGE

Primary language: _____
Secondary language: _____
Is there any family history of speech/language difficulties?
_____
_____
_____

ADDITIONAL INFORMATION

Is there anything else about your child you would like me to know that would help me provide better service?
_____
_____
_____
_____
_____